MEDICAL STAFF POLICY GOVERNING MEDICAL PRACTICES

Subject: Admission, Transfer and Discharge of Patients

Policy Statement: It is the policy of the Medical Staff to ensure the following guidelines for admission, transfer and discharge of patients are consistently observed.

Guidelines:

A. Admission

1. A patient shall be admitted to the Medical Center only by a member of the Active, Associate, or Courtesy Medical Staff in accordance with the privileges they have been granted.

B. Responsibility

1. An appointee to the Medical Staff shall be responsible for the care and treatment of each patient in the Medical Center, for the prompt completion and accuracy of those portions of the medical record for which he or she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the patient, to the referring practitioner, if any, and to relatives of the patient. Primary practitioner responsibility for these matters belongs to the admitting practitioner. When the admitting practitioner is a dentist, oral surgeon, or podiatrist, a physician shall be responsible for the medical care and treatment of such patient.

2. When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another Medical Staff appointee, documentation of the transfer of responsibility and acceptance of the same shall be entered on the order sheet and progress notes.

3. Each practitioner shall assure timely, adequate professional care for his or her patients in the Medical Center by being available or designating a qualified alternate practitioner with whom prior arrangements have been made to attend to practitioner's patients when the practitioner is unavailable. The alternate shall possess the same or similar clinical privileges at the Medical Center as the practitioner and be qualified to provide any required emergency medical treatment or services and any interventional treatment or services to the practitioner's patients. The practitioner shall notify his or her alternate of (i) when the practitioner expects to be unavailable and (ii) when the alternate shall accept responsibility for the practitioner's patients. Failure to notify the alternate of unavailability shall be considered a serious breach of these Policies Governing Medical Practices and may be a basis for disciplinary action. If

there is no qualified alternate available, the practitioner shall continue to provide twenty-four (24) hour care to practitioner's patients.

a. Each appointee to the Medical Staff who will be out of town or unavailable in case of emergency shall indicate, in writing on the Integrated Progress Note, the name of the practitioner who shall be assuming responsibility for the care of the patient during such practitioner's absence. In the absence of such designation, the Administrator, the Chief of Staff or the applicable Clinical Chairperson has the authority to call any appointee to the Medical Staff with the requisite clinical privileges to assume care of the patient.

C. Admission Diagnoses

1. Except in an emergency, no patient shall be admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

D. Emergency Admissions

1. Practitioners admitting patients as emergency admissions shall be prepared to justify the admission as a bona fide emergency. The history and physical examination shall clearly justify the patient being admitted on an emergency basis and these findings shall be recorded on the medical record as soon as possible after admission.

E. Frequency of Patient Attendance

1. All hospitalized patients will be seen on at least a daily basis by the attending physician, or his or her alternate. For regular inpatient admissions, physicians should see their patients and document on a daily basis or may assign an alternate practitioner in their absence. For patients admitted to a nursing unit from the ER, the attending physician should see that patient within twelve (12) hours of admission. For patients admitted to the ICU from the ER, the attending physician should see that patient within six (6) hours of admission. These time frames are guidelines, and certain circumstances will require greater urgency.

F. Appointment of Staff Member

1. Each patient shall be attended by the physician, dentist, oral surgeon, or podiatrist of the patient's choice, within the scope and limits of the practitioner's privileges. A patient seeking admission to the Medical Center who does not or cannot designate his or her choice of a practitioner

shall be referred to the member of the Medical Staff on emergency call who shall then arrange for appropriate care.

G. Admission Information

1. Practitioners admitting patients shall be held responsible for giving such information regarding the patient's condition, including but not limited to alcohol or drug use or mental illness, as may be necessary to assure the protection of other patients and Medical Center personnel and Medical Staff from patients who maybe a source of danger to themselves or others, from any cause whatever.

2. All gunshot wounds, poisonings, self-inflicted wounds and attempted suicides, child abuse and animal bites shall be reported, if required by law, to the appropriate law enforcement agency.

H. Continued Stay

1. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the utilization review plan and/or criteria developed for concurrent review. This documentation shall contain an adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient). This documentation may also contain:

   a. The estimated period of time the patient shall need to remain in the Medical Center; and

   b. Plans for post-hospital care.

I. Transfer

1. A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. Patients who are not stabilized may be transferred to another facility if the attending physician certifies that the benefits outweigh the risks of the transfer. Such certification shall contain a summary of the risks and benefits upon which it is based. A transfer demanded by an emergency or critically ill patient or his or her family is not permitted until the attending physician has explained the seriousness of the condition and the risks of transfer.

2. All pertinent medical information necessary to ensure continuity of care shall accompany the patient to the receiving facility.

J. Discharge

1. Patient shall be discharged only on a written order of the attending practitioner. Should a patient leave the Medical Center against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

K. Death

1. In the event of a patient's death, the deceased shall be pronounced dead by the attending physician or physician designee. The body shall not be released until the attending physician, or authorized alternate, has authorized such release. Exceptions shall be made in those instances of terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Except in cases of terminal illness, the physician shall be responsible for notifying immediate family of a patient death.

References:

- EMTALA 42 U.S.C. §1395dd
- 42 C.F.R. § 489.24
- JCAHO Standards MS. 6, 2003

Form(s):

Medical Executive Committee Approval:	October 22, 2003	March 14, 2005
Board of Directors Approval:	October 23, 2003	April 1, 2005